Kentucky Diabetes Connection

The Communication Tool for Kentucky Diabetes News

AACE
American Association of Clinical Endocrinologists Ohio Valley Chapter

ADA
American Diabetes Association

DECA
Diabetes Educators Cincinnati Area

GLADE
Greater Louisville Association of Diabetes Educators

JDRF
Juvenile Diabetes Research Foundation International

KADE
Kentucky Association of Diabetes Educators

KEC
Kentuckiana Endocrine Club

KDN
Kentucky Diabetes Network, Inc.

KDPCP
Kentucky Diabetes Prevention and Control Program

TRADE
Tri-State Association of Diabetes Educators

A Message from Kentucky Diabetes Partners

The ***Kentucky Diabetes Connection*** newsletter was featured at a poster session of the Centers for Disease Control and Prevention (CDC) Diabetes Translation Conference held in Miami, Florida in May. Over 200 newsletters were distributed to attendees from other states who were interested in creating a similar statewide diabetes communication tool. Since the CDC conference and poster session was held the week prior to the Kentucky Derby, Kentucky's *"Run for the Roses"* theme was featured as an "attention getter" on the poster display. The diabetes newsletter "partners" were listed upon horse saddles and connected by yellow ribbon. Chocolate mints were given out in lieu of mint juleps and horses racing along a track included a description of actions taken to begin this newsletter. Photos displayed below depict the ***Kentucky Diabetes Connection*** poster as well as staff of the Kentucky Diabetes Prevention and Control Program (KDPCP) with Dr. Frank Vinicor, Director of the CDC, Diabetes Translation Division.

Photo at right:
"Kentucky Diabetes Connection" poster display at the CDC Diabetes Translation Conference May 2005

Photo at left:
Dr. Frank Vinicor (center) Director of the CDC Diabetes Translation Division proudly displays the "Kentucky Diabetes Connection" newsletter, and visits with KDPCP staff. From (L) to (R) Marissa Vincent, Paula White, Janice Haile, Dr. Frank Vinicor, Dawn Fraze, Deborah Fillman and Mechelle Coble

CONTROL OF DIABETES IN THE HOSPITALIZED SUBJECT

Sri Prakash L. Mokshagundam, M.D., Endocrinologist, Joslin Diabetes Center at Floyd Memorial Hospital, New Albany, IN and Division of Endocrinology and Metabolism, University of Louisville, Louisville, KY; AACE Member

The epidemic of diabetes mellitus in the United States and the rest of the world have been well recognized as a major cause of mortality and morbidity. It is also becoming clear that the cost of caring for subjects with diabetes will increase over the next several decades. Much of our current approach to the management of diabetes mellitus has focused on outpatient care. However, recent advances in our understanding of the importance of good blood glucose control in the hospitalized subject with hyperglycemia has drawn attention to the need for improving care of diabetes mellitus in hospitalized subjects. These advances have been made possible by the following: demonstration of the relationship between blood glucose levels and outcomes in subjects with stroke and coronary artery disease (CAD); recent studies that clearly demonstrate the benefit of intensive glycemic control in subjects in intensive care and post-coronary artery bypass graft (CABG); and development of guidelines for glycemic control in hospitalized subjects.

Several observational studies have demonstrated the relationship between high blood glucose and poor outcomes in a variety of clinical situations including acute myocardial infarction, stroke, post-CABG, etc. While pre-existing diabetes is the major cause of hyperglycemia in the hospitalized subject, elevated blood glucose is often recognized for the first time during hospitalization. A study by Umipierrez et al has drawn attention to the adverse effect of undiagnosed diabetes in the hospitalized setting. Subjects with "undiagnosed diabetes" had an 18-fold higher mortality compared to nondiabetic individuals. This was even higher than the 3-fold higher mortality in subjects with known diabetes. Also, individuals with "undiagnosed diabetes" were less likely to receive aggressive therapy with insulin, resulting in poor glycemic control. It must also be recognized that in almost all studies of outcomes in hospitalized subjects with diabetes mellitus, admission blood glucose is related to poor outcomes. This emphasizes the need for good blood glucose in the outpatient setting to improve outcomes during hospitalization.

Further evidence of the role of blood glucose in mortality and morbidity in hospitalized subjects is derived from intervention studies, particularly in the intensive care unit (ICU) and after CABG. The use of continuous variable insulin infusion to maintain "tight" blood glucose control has now been clearly shown to reduce mortality and morbidity in the intensive care setting and in subjects post-CABG. Van den Bergh et al clearly demonstrated reduction in ICU and in-hospital mortality in subjects in an Intensive Care Unit. Blood glucose levels in intensively treated subjects were maintained at around 100 mg/dl compared to 150 mg/dl in the control group. In addition, intensive treatment also resulted in lower rates of sepsis, acute renal failure, anemia, and ICU neuropathy. Furinary et al have shown that continuous variable insulin infusion post CABG significantly reduces perioperative mortality and lowers risk of deep sternal wound infection. Furthermore, use of intensive glycemic control in the perioperative period is highly cost-effective. In view of these and other studies, intensive glycemic control with use of continuous variable insulin infusion has been increasingly recognized as the standard of care for diabetes. ***A variety of protocols have been published and found to be effective and safe for routine clinical use in the ICU. Some of these protocols are listed below and can be obtained at Appendix of Technical Review "Management of Diabetes and Hyperglycemia in Hospitals," http//care.diabetesjournals.org.***

While recent studies mentioned above have provided a sound rationale for management of hyperglycemia in the ICU and post-CABG subjects, the same cannot be said for the usual hospitalized patient with hyperglycemia. The lack of clear guidelines has made it more difficult to implement changes. While large clinical studies in Type 1 (DCCT) and Type 2 (UKPDS) diabetes mellitus have established the glycemic targets to prevent long term microvascular complications, similar studies establishing clear glycemic targets in the hospitalized subject are lacking. Such studies are difficult to design due to multiplicity of variables that need to be evaluated. These include type of diabetes, pre-admission glycemic control, co-morbidities, pre-admission regimens for treatment of diabetes, type of surgical procedure, hospital management of blood glucose and nondiabetes related variables. The Consensus Conference assembled by the American Association of Clinical Endocrinologists (AACE) has provided a beginning in moving towards addressing this issue. The American Association of Clinical Endocrinologists (AACE) recently published general guidelines that should be helpful in setting goals for glycemic control in hospitalized subjects. For the non-ICU subject a Fasting Blood Glucose of < 110 mg/dl, Peak Blood Glucose of < 180 mg/dl is recommended. For the ICU subject, a blood glucose level of < 110 mg/dl is recommended. (Diabetes Care 27:553-91, 2004).

Several barriers to good glycemic control in the hospitalized subject have been recognized. These factors include individual patient related factors, inadequate understanding of the complexities of diabetes management by the health care provider, and deficiencies in the health care system that make it difficult to implement necessary changes in health care delivery to improve outcomes. Management of diabetes mellitus has increased in complexity with the availability of several types of insulin and insulin analogs, oral agents, insulin delivery systems, and monitoring devices. These may not be familiar to the health care providers managing diabetes mellitus in the hospital setting. While outpatient management of diabetes mellitus places emphasis on empowering the patient to make decisions regarding their blood glucose control, hospitalized subjects have to relinquish decision making to health care providers who are often not familiar with the individual regimens. Allowing the patient to participate in the decision making process, when possible, could make it easier to control blood glucose in the perioperative period.

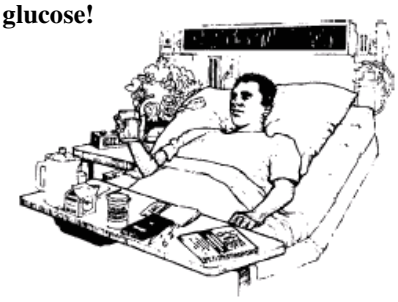
Wide variations in diet and physical activity in the hospitalized subject contributes to the difficulty in managing

blood glucose level. Delay in meal time, "NPO" status for procedures, and use of parenteral nutrition are common in the hospitalized subject and contribute to difficulty in designing management regimens. Diets often vary significantly from the usual diet of the subject in ambulatory setting. Physical activity is encouraged and plays a significant role in improving blood glucose control in the outpatient setting. Therapies that are designed to be effective with a certain level of physical activity may not be effective when an individual is inactive. The need to discharge patients from the hospital early allows little time to make necessary therapeutic adjustments.

Despite these limitations, recognition of common errors and use of sound diabetes management practices will greatly improve diabetes care in the hospitalized subject. Some common errors in the management of the hospitalized subject with diabetes mellitus include the following: discontinuation of previous insulin regimen; continuation of previous regimen with no adjustment for dietary changes; over utilization or inappropriate use of insulin "sliding scales"; inappropriate nutritional recommendations; discontinuation/"holding" insulin when blood glucose near normal; lack of glycemic goal; and lack of individualization of treatment.

It is possible to develop effective protocols for the use of therapies for the management of diabetes in the hospitalized subject. A team approach including the nurse, diabetes educator, dietician, pharmacist, attending physician, and most important, the patient, would be the most effective means of improving care in the hospital. An endocrinologist, when available, could play a consultative / advisory role in developing and implementing the protocol. Having written protocols with clear guidelines for monitoring and action will greatly reduce errors and improve adherence to protocol. Input from all members of the team should be encouraged. Insulin is one of the most potent medications and is considered one of the leading causes of drug-induced problems in the hospital setting. Often, the fear of hypoglycemia is an impediment to effective use of insulin. Subcutaneous insulin protocols would be very helpful. Essential components of a good subcutaneous insulin protocol include guidelines which: provide tight glucose control without hypoglycemia; clearly outline blood glucose monitoring frequency; define the target blood glucose range; contain programmed insulin orders - prandial & basal insulin preparations, timing & doses in units; define lag times for prandial insulin; incorporate correction dose algorithm; provide "physician notification" parameters for high & low blood glucose; and provide hypoglycemia treatment guidelines or reference to hypoglycemia protocol.

Awareness of the need to maintain good glycemic control in hospitalized subjects remains low among physicians and other healthcare providers. **Educating healthcare providers involved in the care of subjects with diabetes mellitus is critical to improving outcomes in hospitalized subjects with high blood glucose!**



OSTEOPOROSIS—ANOTHER COMPLICATION OF DIABETES?

Zouhair Bibi, MD, Endocrinologist, Medical Director, Joslin Diabetes Center at St Mary's Medical Center, Evansville, IN; AACE Member; TRADE Honorary Member

Osteoporosis is an under-appreciated complication of diabetes. As the population ages, osteoporosis increases. Since the life expectancy of people with diabetes has increased, the assessment of skeletal health is an important component of routine care of patients with diabetes.

Several studies have shown that patients with Type 1 diabetes have a lower bone mass density (BMD) and a 7 to 12 fold greater relative risk of hip fracture than a patient without diabetes. Subsequent studies found that the forearm BMD in children with only 4-6 years of Type 1 diabetes was 20-50% lower than that of control subjects.

In patients with Type 2 diabetes, there is conflicting data about BMD. However, the evidence that people diagnosed with Type 2 diabetes are at greater risk for osteoporosis is increasing. The Rotterdam Study found higher bone mass among women with diabetes compared with those without diabetes. *The Study of Osteoporosis Fractures in Women Older Than 65 with Type 2 Diabetes* found an increased risk of hip and proximal humerus fractures despite a higher BMD in those patients. Some studies have reported that the duration of diabetes is associated with a higher risk of hip fracture and that the fracture risk is higher among insulin treated diabetics.

So is osteoporosis another complication of diabetes?

Indeed, the increased risk of osteoporosis in diabetes could be a combination of numerous variables. One possible source of poor bone quality is the micro-vascular disease associated with diabetes. Women with diabetes are at increased risk for menstrual dysfunction, which predisposes osteopenia secondary to estrogen deficiency. Hypercalciuria has long been noted in patients with poorly controlled diabetes. Another potential risk factor for osteoporosis is the decreased osteoblast function secondary to hyperglycemia and the lower levels of insulin-like growth factor I, an anabolic hormone that maintains healthy bone formation. In addition, in diabetes, there is a higher incidence of eating disorders, Graves's disease, and celiac sprue, which may also explain the increased risk of osteoporosis. Lastly, diabetic retinopathy and peripheral neuropathy increase the risk of falls and fractures.

Diabetes health professionals should continue to strive for better and tighter glycemic control to prevent diabetes complications and reduce risk for osteoporosis. Physicians as well as diabetes educators should address the following lifestyle issues: regular exercise; smoking cessation; alcohol consumption; and adequate calcium / vitamin D consumption. Medications should be reviewed each visit and visual assessment should be performed by an ophthalmologist. Other therapeutic interventions like the use of walkers, diabetic shoes, and hip protectors are also key to prevent the risk of falls and fractures. In summary, care of patients with diabetes should include a thorough assessment of bone health.

KENTUCKY'S WAR ON WEIGHT & TYPE 2 DIABETES IN YOUTH: THE BATTLE CONTINUES AS A LEGISLATIVE VICTORY EMERGES

Dawn Fraze RN, BSN, CDE, Regional KDPCP Coordinator, LincolnTrail District Health Department, KDN Member, GLADE President

As our nation prepared for war, in the face of terrorist attacks in 2001, another threat to our health and our children's health was looming. Apathy regarding the ever-growing size of our nation's individuals (whose increasing weight was being fueled by excessive calorie intake and little to no physical activity) was beginning to become evident. This risk became more apparent as we found ourselves facing more adults and even children developing chronic diseases directly related to overweight and obesity. Many states, and even the nation, called for and began to implement steps to turn this tide. **Though Kentucky has carved out a recent legislative victory to improve its school health environment, the battle continues. The stakes are high and action is needed to keep Kentucky's important first steps going in the right direction.**

The trends are alarming! According to National Health and Nutrition Examination Survey (NHANES), overweight, obesity, and physical inactivity among adults and children are significant risk factors for several chronic diseases, including diabetes, and the indicators are not improving. Nationally, over 129 million adults in the United States are overweight (BMI >25) or obese (BMI >30). The NHANES show that in the last decade the U.S. experienced a 9.2% increase in the number of adults who are overweight or obese, representing nearly two thirds of the U.S. adult population. More and more children and teens are also overweight, continuing the pattern the survey documented over the past two decades when the number of overweight children more than doubled and teens more than tripled. The survey indicated that nearly 16% of children and adolescents are overweight as defined by a body mass index (BMI) for age greater than the 95th percentile. An additional 15% of children and adolescents are at risk for overweight (BMI for age between the 85th and 95th percentile). (1). In Kentucky, almost 63% of adults are overweight or obese. Almost 30% of Kentucky's high school students and over 34% of Kentucky's middle school students are overweight or at risk of overweight. Among the youngest Kentuckians, 35% of children age 2, 3 and 4 are already overweight or risk for overweight. (4).

Overweight and obesity substantially increase the risk of morbidity and mortality from hypertension, dyslipidemia, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, and respiratory problems, as well as endometrial, breast, prostate, and colon cancers (2). Of particular concern is the relationship of excess body weight to the risk of type 2 diabetes. Until recently, type 2 diabetes has been seen almost exclusively in adults, primarily those who are overweight and inactive. However, as the typical American child is becoming less active, watching more television, and eating a diet higher in calorie content, more and more children and adolescents are being diagnosed with type 2 diabetes. In Kentucky, 13% of high school students have been told by a health care professional that they are at risk of developing diabetes. Only 13% of Kentucky's high school students meet the five-a-day guideline of consuming five or more servings of fruits and vegetables a day. Almost half of these students buy sodas at least once a day from school vending machines. Thirty-one percent of these high school students watch more than 3 hours of television each day. In addition, one in ten gets no physical activity, with only one out of three enrolled in PE class. (4). In fact, Kentucky has the highest percentage of any state for lack of physical activity and ranks 5th among the states for highest prevalence of obesity among those 18 years and older (6).

Overweight and obesity have reached epidemic proportions. The former Surgeon General, David Satcher, M.D., PhD, issued a warning in December of 2001 with a call to action to prevent and decrease overweight and obesity (7). Kentucky led the forefront implementing one of the Surgeon General's suggested actions having already formed a task force in May of 2001 to address the problem of obesity among Kentucky's youth. Led by Kentucky's former Lieutenant Governor, Stephen L. Henry, M.D., the taskforce was comprised of individuals, healthcare professionals, private providers, hospitals, universities, local health departments, the state department for public health, and the state department of education as well as local, state, and national school, education, and health promotion organizations. Following the Surgeon General's identification of schools as a key setting for this public health issue, the taskforce made proposals to Kentucky legislators during the 2002, 2003, 2004 and 2005 sessions to improve nutrition and physical activity in schools.

At last, during this year's legislative session Kentucky Senate Bill 172, "The School Health and Nutrition Bill", was approved by both houses. The law, effective as of June 20th, 2005, requires the following of KY schools: 1) specific credentialing and annual nutrition education hours for persons responsible for meal planning; 2) limits retail fast food in the cafeteria to one time per week; 3) restricts competitive beverage sales in elementary schools to "school day approved beverages", which include water, 100% fruit juice, low fat milk and beverages that contain no more than 10 grams of sugar per serving; 4) establishes penalties for competitive food violations; 5) requires site-based councils to develop and implement a policy for daily physical activity in elementary schools, allowing up to 30 minutes of physical activity to be counted as instructional time; 6) requires an annual report on the school nutrition and physical activity environment; and 7) requires the KY Board of Education (KBE) to promulgate regulations addressing the nutritional content of foods and beverages sold in school stores, vending machines, canteen and a-la-carte sales (5).

The KBE has completed its first draft of nutritional regulations for the above items which may be viewed in full at: http://www.education.ky.gov/users/spalmer/702%20KAR%206090.pdf. This draft includes beverages that meet the following: milk that has no more than 2% fat, only 100% fruit and/or vegetable juice, any other beverage that contains no more than 10 grams of sugar per serving; sodium content that

does not exceed 40 mg per serving; caffeine free; and a volume size that does not exceed 16 ounces except for unflavored, unsweetened, non-carbonated water. For food items the draft regulation includes: calories from fat shall not exceed 30% with no more than 10% saturated fat; calories from sugar shall not exceed 32%; sodium restrictions on specified food items; several items including chewing gum and hard candies would not be allowed; and portion sizes would be limited for specified items (3). These regulations are currently undergoing review by various stakeholders working with the Kentucky Department of Education. A second draft of the regulation shall be presented at the next state board meeting this August at which time the KBE plans to vote on the regulation. **Those wishing to weigh in on the regulation should contact KBE members through Kentucky Board of Education, 1st floor, Capital Plaza Tower, 500 Mero Street, Frankfort, KY 40601, e-mail: mmiller@kde.state.ky.us . It is very important that board members hear from the public as these promising regulation proposals may not hold without public support.**

Our youth spend a large proportion of their time, and eat a large proportion of their meals at school. Thus there exists many opportunities to engage and reinforce healthy eating practices and regular physical activity. By advocating for a school environment with healthier choices, we may afford our youth opportunity to learn and practice healthier lifestyles and grow to be healthier adults. They may then pass this on to following generations, ultimately leading Kentucky and our nation to a healthier future. That will truly be a victory for Kentucky's war on weight and type 2 diabetes in youth!

References Available Upon Request

KENTUCKY DEATH CERTIFICATE DATA IS FOCUS OF CDC PRESENTATION

Kentucky's death certificate data from 2002 and 2003 was an area of focus and interest during a recent presentation at the 2005 National CDC Diabetes Translation Conference. Robert N. Anderson, PhD, CDC (Mortality Statistics Branch, Division of Vital Statistics, National Center for Health Statistics), examined data collected from Kentucky's new diabetes specific questions now required on KY death certificates as "checkboxes". Dr. Anderson offered insight as to how Kentucky's data could be improved.

Background: For years, diabetes advocates have felt that diabetes was underreported in national and state death certificate data. Complications that diabetes causes or contributes to (myocardial infarction, stroke, kidney failure, etc.) may be listed on death certificates instead of "diabetes" itself. This has been cause for concern because funding and community planning may be directly related to diseases or conditions causing the greatest numbers of death.
Thus in 2002, in order to try to obtain more accurate data about Kentucky's burden of diabetes, KY legislators passed a law that required 2 questions be added to Kentucky death certificates: 1) Did the deceased have Diabetes? and 2) Was Diabetes an immediate, underlying, contributing cause of or condition leading to death?

In examining the newest KY diabetes death certificate data, Dr. Anderson felt there were both positives and negatives. On the upside, Dr. Anderson felt that the newly required diabetes "checkboxes" allow for identification of diabetes, serve as a reminder to the certifier to report diabetes, and may help to assess the underreporting of diabetes in the "cause of death" section of the death certificate.

However, Dr. Anderson also stressed that the new KY data requirements MAY actually CAUSE underreporting in the "cause of death" section of the death certificate. Specifically, he pointed out that only what is **actually written in the "CAUSE OF DEATH" section on KY death certificates is counted in mortality data.** In other words, the answers to the diabetes questions on KY death certificates are NOT being included in the KY mortality numbers. Thus Dr. Anderson expressed concern that improper completion of KY death certificates – diabetes not being "written in" the "cause of death" section even when the required diabetes questions were answered positively – has led to an overall decrease in diabetes reporting on death certificates. Dr. Anderson said he felt providers completing the KY death certificate may think they have reported diabetes by answering the required questions specific to diabetes --- and thus do not realize that they must also **write this information in the "Cause of Death" section for it to be counted in the mortality data.**

Dr. Anderson said that since the diabetes specific questions were added to the Kentucky death certificate, KY mortality data has increased in the reporting of diabetes in Part I of the KY death certificate (Immediate Cause – final disease or condition resulting in death) versus a decrease in the reporting of Part II of the KY death certificate (Significant conditions contributing to death but not resulting in the underlying cause given in Part I) .

Dr. Anderson recommended that training be conducted for certifiers completing KY death certificates and also agreed to work with KY diabetes advocates to improve KY diabetes mortality data. He also agreed to work with the Kentucky Diabetes Prevention and Control Program to publish an article regarding his analysis of the KY diabetes mortality data.

"Taste of Tuscany" JDRF Gala Raises $164,000 for Diabetes!!

More than $164,000 was raised in the search for a cure for diabetes in the "Taste of Tuscany" Gala at Louisville's Seelbach Hilton Hotel on June 4! The Gala, which honored Ford Kentucky Truck Plant Manager, Gary Laden, is one of the most important annual fundraising events for the Kentuckiana Chapter of the Juvenile Diabetes Research Foundation International ("JDRF").

The event, chaired by Eric and Jenny Gunderson, attracted an estimated crowd of 400 to the ballroom of the downtown Louisville hotel. The "Taste of Tuscany" Gala included wine tasting, hors d' oeuvres, dinner, both silent and live auctions, and special entertainment.

If you have any questions or would like additional information, please contact Katy Maloy, Special Events Coordinator, Juvenile Diabetes Research Foundation, Kentuckiana Chapter, 502- 485-9397 or kmaloy@jdrf.org .

FROM RESEARCH TO REALITY

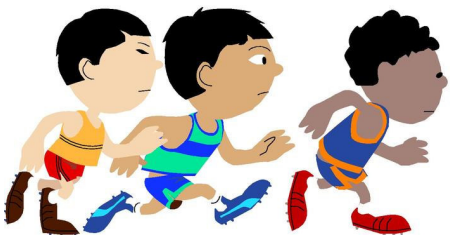
The Campaign to Accelerate the Cure for Diabetes

JDRF Plans Walks in Kentucky to Raise Money for the Cure of Diabetes

2005 Greater Louisville Walk to Cure Diabetes
Saturday, September 17, 2005
Bowman Field/Seneca Park - Louisville, Kentucky
Registration at 8 a.m. Walk at 10 a.m.

2005 Bluegrass Region Walk to Cure Diabetes
Saturday, October 8, 2005
Jacobson Park - Lexington, Kentucky
Registration at 8 a.m. Walk at 10 a.m.

For information on these events, go to www.jdrf.org or call the Kentuckiana JDRF chapter at (866)485-9397



Make Plans to Offer Flu/Pneumonia Vaccines to Diabetes Patients!

As health care facilities and health departments across Kentucky begin to plan special efforts to administer flu and pneumonia vaccines this fall, the Kentucky Diabetes Prevention and Control Program (KDPCP) encourages health care professionals and diabetes educators to make a special effort to reach out to those with diabetes! For example, consider offering flu / pneumonia vaccines at diabetes events held in October and November. In addition, public education and media releases regarding diabetes and the importance of flu and pneumonia vaccination would be beneficial. Free posters and brochures may be downloaded from www.cdc.gov/flu/professionals/patiented.htm or you may contact CDC at 1-800-232-2522 and request a CD with flu / pneumonia educational materials. A Kentucky specific flu poster (printed in this newsletter), developed by the KDPCP regional team of the Louisville Metro Health Department, is also available through the KY Publications (Pamphlet) Library – fax request to 502-227-7191.

FLU Immunizations Guidelines (In Diabetes)

The Advisory Committee on Immunization Practices (ACIP), the CDC, and the American Diabetes Association recommend the following flu guidelines for persons with diabetes who do not have egg allergies or other contraindications (1,2,4):

- The person with diabetes *(6 months old or older)* should receive a yearly flu *(influenza)* vaccine beginning each October.
- The child with diabetes under the age of 9 receiving the flu shot for the first time should receive the vaccine in 2 doses at least 28 days apart.
- For the person with diabetes, the flu vaccine should be the "inactivated" type (not the live virus).
- Persons with diabetes should NOT use Flu Mist or intranasal (live) influenza vaccine.

Pneumonia Immunization Guidelines (In Diabetes)

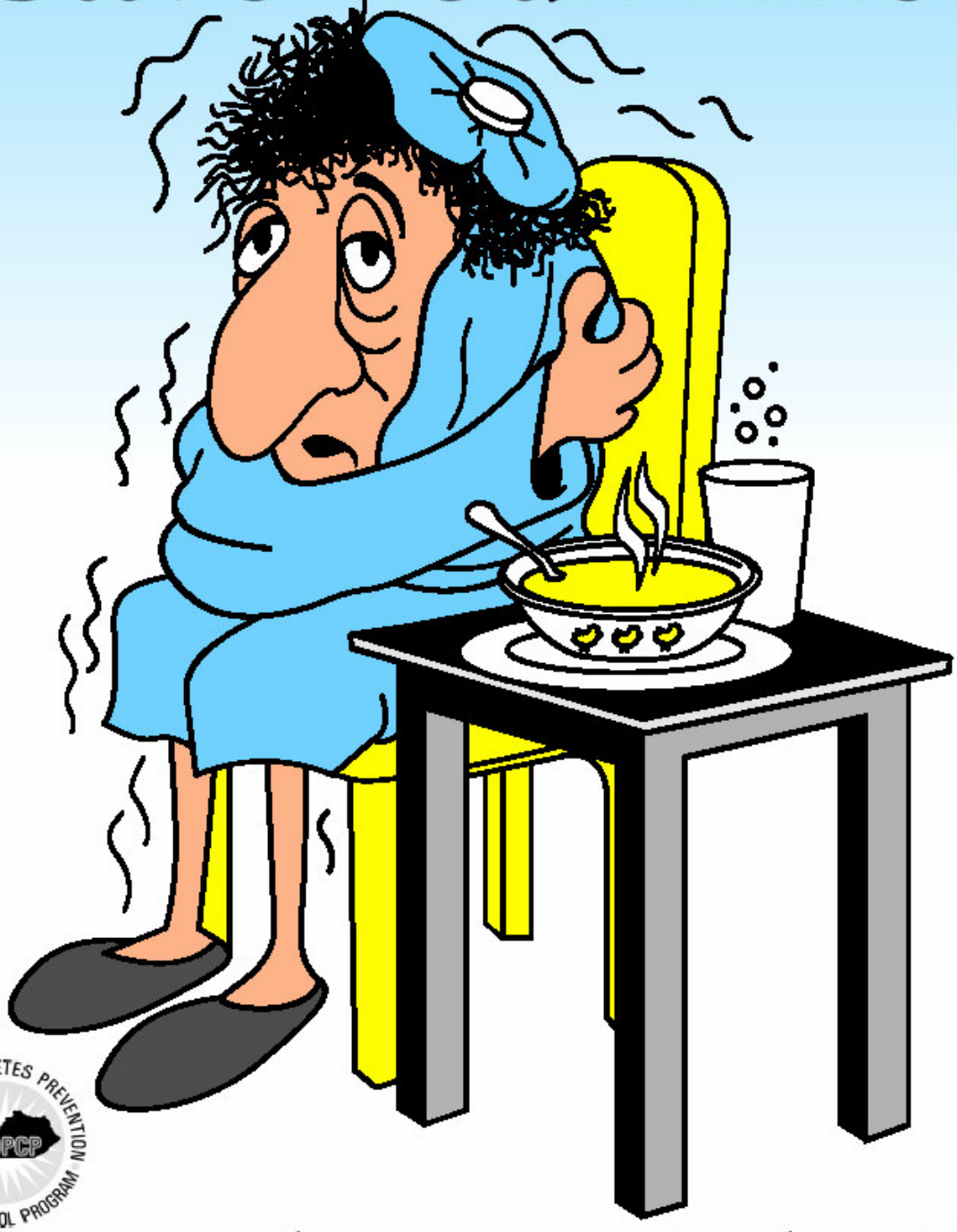
In addition, the Advisory Committee on Immunization Practices (ACIP), the CDC, and the American Diabetes Association recommend the following pneumonia guidelines for persons with diabetes who do not have other contraindications (1,2,4):

- The person with diabetes *(age 2 or more)* should receive a pneumonia vaccine (PPV 23).
- A one time revaccination may be recommended for individuals older than 65.

For more complete information, contact your health care provider and / or the National Immunization Information Hotline: The National Immunization Information Hotline is supported by the Centers for Disease Control & Prevention and provides information for the public and health care providers 8 am - 11 pm Monday through Friday. You may reach them by telephone *(English)* 1-800-232-2522, or on the web at http://www.vaccines, or ashastd.org.

Have Diabetes?

A Flu Shot Could Save Your Life!



KENTUCKY DIABETES PREVENTION AND CONTROL PROGRAM
KDPCP

Do You Need a Pneumonia Shot, Too?

Contact your local Doctor, Health Care Provider or Health Department

TEACHING GLUCAGON IN KENTUCKY SCHOOLS - AN UPDATED ADVISORY OPINION STATEMENT FROM THE KENTUCKY BOARD OF NURSING

As follow-up to the glucagon article written by Eloise Campbell, NP, CDE (GLADE member), Clark Memorial Hospital in Jeffersonville, IN, the following information regarding glucagon usage in Kentucky schools is being printed. The KY Board of Nursing advisory opinion statements for *"Roles of Nurses in the Supervision and Delegation of Nursing Acts to Unlicensed Personnel"* and *"School Nursing Practice"*(both publications updated in February 2005) were reviewed for content specific to glucagon usage.

Both Board of Nursing publications either list or refer to the following statement: **"FOR INTERVENTION IN LIFE-THREATENING SITUATIONS, A REGISTERED NURSE MAY TEACH AND DELEGATE TO NON-NURSE SCHOOL EMPLOYEES THE PREPARATION AND ADMINISTRATION OF INJECTABLE GLUCAGON, EPINEPHRINE HYDROCHLORIDE (USING AN ADMINISTRATION SYSTEM SUCH AS "EPI PEN") AND DIAZEPAM SUPPOSITORY. THE MEDICATIONS WOULD BE GIVEN ACCORDING TO WRITTEN ESTABLISHED POLICIES AND PROCEDURES OF THE SCHOOL SYSTEM."**

Thus the nurse may teach glucagon administration to unlicensed school employees in a life-threatening situation according to written policies and procedures established by the school system.

Eli Lilly, the manufacturer of glucagon, was contacted by KDPCP state staff regarding availability of professional glucagon instruction / check-off sheets and sample emergency glucagon kits (for teaching / checking off school staff in glucagon usage). KDPCP staff was told by Eli Lilly that they did not have the requested products nor did they have plans to develop these products.

If you have developed tips or have tools regarding teaching glucagon injections to school personnel (with check-off sheets), please share them with this newsletter through janice.haile@grdhd.org .

NOTE: THE KENTUCKY DIABETES CONNECTION REGRETS LISTING THE WRONG WORKSITE FOR ELOISE CAMPBELL IN THE SPRING 2005 ISSUE.

WORKING TOGETHER TO IMPROVE HEALTH CARE IN KENTUCKY

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State government, health insurers, professional organizations, and Health Care Excel of Kentucky (HCEK), the Medicare Quality Improvement Organization (QIO) for the Commonwealth, are joining together to coordinate statewide quality improvement efforts and measures through the Kentucky Health Quality Agenda (KHQA).

KHQA is a statewide collaborative effort to improve the quality of health and health care in Kentucky. Improvement in quality of care requires system change, including dispersion and use of improvement knowledge and tools; therefore, health care stakeholders are working collaboratively to share best practices.

"Although Kentucky has health care providers who deliver exceptional care, the level of care is not consistent across the Commonwealth," says KHQA Chairman Jeffrey Rice, MD, MS. "Inconsistency leads to inefficiencies, waste, and unwarranted variation in the quality of care."

During each meeting, participating organizations generate ideas for potential adoption by members of the committee. Participants focus upon a challenge, consider the best clinical and improvement practices, generate ideas, and adopt specific actions that stimulate improvement. **To date, participants have adopted and agreed to promote the Kentucky Diabetes Network's Diabetes Care Tool, which serves as a guideline for the continuing care of adults with diabetes**.

KHQA quarterly meetings are held at the Kentucky Hospital Association (KHA) headquarters. Participants also correspond regularly through the use of an electronic listserv.

Organizations participating in KHQA include (in alphabetical order) Anthem Blue Cross and Blue Shield, Bluegrass Family Health, Bridges of Excellence, CHA Health, Health Care Excel of Kentucky, Humana Health Plan, Inc., Kentucky Cabinet for Health and Family Services, Kentucky Department for Public Health, Kentucky Diabetes Prevention and Control Program, Kentucky Diabetes Network, Kentucky Hospital Association, Kentucky Medical Association, Kentucky Nurses Association, Pikeville College School of Osteopathic Medicine, UnitedHealthcare of Kentucky, University of Louisville School of Medicine, and University of Kentucky School of Medicine.

NOTE: *Health Care Excel Kentucky (HCEK) is a private, not-for-profit consulting company dedicated to assisting health care professionals deliver quality, cost-effective care in a dynamic environment. HCEK is known for its use of analytical and evaluative approaches, extensive involvement of physicians, ancillary health care disciplines, and medical care providers.*

KDN Workgroup Announces Winners of Diabetes Awareness Contests

Dawn Fraze RN, BSN, CDE, Regional KDPCP Coordinator, LincolnTrail District Health Department; KDN Member; GLADE President

Diabetes has reached epidemic proportions. Health care providers are finding more and more children and teens with type 2 diabetes, a disease usually seen in people over age 40! In an effort to raise awareness about this growing concern, in October of 2004, the Kentucky Diabetes Network, Inc. (KDN) sponsored its third Diabetes Awareness Contest distributing 1200 contest packets to schools and student clubs across the state.

To enter the contest, students were asked to address the prevention of type 2 diabetes, specifically in youth, while promoting the healthy eating and physical activity message *"Type 2 Diabetes: Move It, Lose It, Prevent It!"* The diabetes awareness contest offered awards in three age categories which focused on different tasks. The age categories and tasks were as follows: for grades 1-4 -- drawing/painting; for grades 5-8 -- poem; and for grades 9-12 -- video PSA. Submissions were judged based on accuracy, delivery of message, and creativity. Jasmine Osborne, Miss Heartland Teen 2005, whose message is *"DREAMS: Diabetics Realizing, Experiencing, and Achieving Many Successes"* presented the following winners with a cash prize:

- Drawing category($250) *Courtney Hayes of Charles Russell School in Ashland;*
- Poem category ($250) *Kaleb Parks of Fifth District Elementary in Morgantown;*
- Video category ($500) *Mike Simpson, Jordan Schneider, Regina Durkan, and Jordan Logsdon of Elizabethtown High School.*

Linda J. Hawkins provided autographed copies of her children's book, *Alexander and the Great Vegetable Feud*, to all grade schools who participated in the contest. There have been nearly 3.5 million exposures to the prevention message promoted by the winners of this and last year's contests.

With the help of the Kentucky Department for Public Health's State Obesity Prevention Program, the winning diabetes prevention video will be broadcast statewide between July & September of this year. Plans to create calendars with the winning poems and drawings are also underway.

Many thanks to all the Kentucky Diabetes partners who have participated and contributed toward the success of this diabetes prevention project! Please help get the word out about diabetes and how it is affecting our young people. Beta copies of the winning 30 second video as well as copies of the winning drawing and poem are available upon request by contacting Dawn Fraze at 1-800-280-1601 or (270)769-1601 Ext. 129 or email dawns.fraze@ky.gov

Congratulations!

KDN Diabetes Awareness Contest Winners , (L) to (R), front row: Regina Durkan, Jordan Logsdon; back row: Courtney Hayes, Jordan Schneider, Mike Simpson, Kaleb Parks, Jasmine Osborne, Dawn Fraze

Winning Drawing by: Courtney Hayes, 3rd grade, Charles Russell School, Ashland KY

Winning Poem by: Kaleb Parks, 5th grade, Fifth District Elementary School, Morgantown, KY

Diabetes

Children who are overweight,
Don't know the risk they take!
Hispanic and African too,
Diabetes can affect you!
Vegetables, fruit,
and exercise too,
Are ways to stop
Diabetes affecting you!
Don't ignore the signs,
Go to the doctor on time!

Written Statement Presented by Video PSA Winners:

"*We entered the diabetes contest in order to increase diabetes awareness around our community. We all have a family member or a friend with diabetes, and if there is a way to prevent an illness, it should be known to everyone. Exercise and nutrition were our focus in the public service announcement. We are grateful to be given a chance to be involved in your network.*" Thank you, Gina Durkan, Jordan Logsdon, Jordan Schneider, and Mike Simpson.

American Diabetes Association Announces First Chair From Kentucky To Lead The Organization

Larry Smith from Lexington will serve as the new National Chair of ADA

The American Diabetes Association (ADA) Bluegrass Council is honored to announce that at the 65th Annual ADA Meeting and Scientific Sessions, held recently in San Diego, Larry Smith, a Lexington KY volunteer, was elected National Chair of the American Diabetes Association! This is the highest volunteer position in the entire organization and the first time that anyone from Kentucky has held the position.

Larry Smith is the founder and manager of Smith Market Research, a national marketing research and consulting firm, located in Lexington. He became involved with the ADA shortly after his daughter was diagnosed with type 1 diabetes and has served in a variety of volunteer leadership roles for the ADA at both the national and local levels. Throughout more than 15 years of service to the Association, Larry has focused on issues related to marketing. He helped to develop the research conducted to determine the public's awareness of ADA, which formed the basis for the organization's strategic marketing plan. He also helped to facilitate implementation of the Association's new organizational structure in the mountain states and mid-America regions and was the first chair of the southern region.

We thank Larry for his many years of service and amazing commitment to the American Diabetes Association. For additional information or other volunteer opportunities contact (859) 268-9129.

R. Stewart Perry Named Vice Chair Of The Board-Elect Of The American Diabetes Association

R. Stewart Perry, from Lexington named vice chair of ADA Board Elect

The American Diabetes Association (ADA), announced that R. Stewart Perry, of Lexington, KY, was named the Vice Chair of the Board-Elect at the organization's 65th Annual Meeting and Scientific Sessions held recently in San Diego, CA.

Since 1983, Mr. Perry and his father have been the co-owners of Dick Perry & Stewart Perry State Farm Insurance. Mr. Perry is and continues to be very involved in several community and civic activities, including being a member of the Kentucky Diabetes Network, and a founding member of the Fayette County Diabetes Coalition. Mr. Perry has been active in the ADA since being diagnosed with type 2 diabetes in 1990. He left a legacy of fundraising events from his Chairmanship of the Bluegrass Chapter, served as Vice-Chair on the Kentucky Affiliate Board of Directors and was Chair-Elect when it became part of the Southern Region.

At the National Level, Mr. Perry has served on the National Community and Volunteer Development committee, chaired the Advocacy Task Force of the Program Committee, and was most recently Chairman of the Advocacy Committee. While he was Chairman, the Association's Government Affairs and Advocacy division expanded its grassroots efforts; helped pass diabetes care in schools legislation in Hawaii, Kentucky, and Texas; helped advance stem cell research in California and Washington State; and won a major court victory concerning employment discrimination against an individual with diabetes.

Congratulations Stewart and Larry!!

2005 Family Fun Diabetes Day To Be Held In September

The American Diabetes Association is sponsoring a Family Fun Diabetes Day on September 17th from 9 a.m. to 1 p.m. at Kentucky Horse Park in Lexington, KY. This day is designed for children with diabetes and their immediate family. The cost is $5.00 per family; however, no one will be turned away because of an inability to pay.

The goal of the Family Fun Diabetes Day is to give parents and children the opportunity to meet and build relationships with other families that have a common concern.

The families will have the opportunity to enjoy carnival games, inflatables, hayrides, pony rides, crafts, educational booths, lunch and much more!

For registration brochures or additional information, please contact Lisa Edwards at (859) 268-9129 or lisa.edwards@diabetes.org

American Diabetes Association®

Cure • Care • Commitment®

DRIVERS LICENSE INFORMATION NOW AVAILABLE FOR PEOPLE WITH DIABETES

People with diabetes sometimes face difficulty in obtaining or renewing their private drivers licenses. One big problem is simply understanding how each state handles private (non-commercial) licensing for people with diabetes. To remove this hurdle, the American Diabetes Association has compiled detailed information on the regulations and policies affecting drivers with diabetes in each of the 50 states and the District of Columbia.
This information is now available on the ADA web site www.diabetes.org/privatedriving or by calling 1-800-DIABETES.

Visitors to the site can select their state to get more detailed information on that state's policies. The page for each state includes information on license application questions that may relate to diabetes, procedures for medical evaluations of drivers with diabetes, state policies regarding episodes of altered consciousness due to hypoglycemia or hyperglycemia, and procedures for appealing licensing decisions.
For more information contact: Brian L. Dimmick, Staff Attorney, Government Affairs and Advocacy, American Diabetes Association, 1701 N. Beauregard St., Alexandria, VA 22311, 703-299-5506, bdimmick@diabetes.org, http://www.diabetes.org/privatedriving

KY Drivers License – Diabetes Specifics

1. **In KY, are applicants for a driver's license asked questions about diabetes?**

The driver's license application (first time and renewal) asks the applicant whether he or she has any physical/mental conditions which affect his or her driving abilities, whether he or she has had a seizures or blackout within the last 90 days, and whether he or she has had a blackout within the last three years. If an applicant answers "Yes" to any of these questions, he or she is required to have a medical examination and evaluation performed by a physician of his or her choice.

2. **In KY, what other ways does the state have to find out about people who may not be able to drive safely because of a medical condition?**

The state accepts reports of potentially unsafe drivers from police officers, the courts, family, friends, other citizens, and hospitals. Anonymous reports are not accepted, and reports are not investigated by the agency before the driver is contacted. An examination of the driver's qualifications may also be triggered by a report that a driver suffered a blackout prior to an accident or by the observations by licensing agency personnel during the application or renewal process.

3. **In KY, what is the process for medical evaluations of drivers?**

If the licensing agency receives notice that a person who holds or has applied for a driver's license has a medical condition (including diabetes), either because of answers to questions on the license application or one of the other sources listed above, and believes the condition could interfere with the safe operation of a motor vehicle, that individual must undergo a medical evaluation, at personal expense, within 45 days. The medical evaluation form contains questions about the type of diabetes, insulin or other medications used, the presence of neuropathy or other complications that could affect driving, significant hypoglycemic episodes in the past year, alcohol or drug use that could interfere with treatment, and whether the patient is compliant with medication. Non-medical administrative staff within the licensing agency evaluate the medical forms according to state medical standards (see below).

4. **In KY, who makes decisions about whether drivers are medically qualified?**

Licensing agency personnel normally make a licensing decision based on the medical information submitted. When the reviewers of the medical forms encounter a case in which medical or rehabilitation expertise is needed to evaluate driving ability, they will refer the case to the state's independent Medical Review Board.

5. **In KY, has the state adopted specific policies about whether people with diabetes are allowed to drive?**

Yes. No diabetic neuropathy or other complication that interferes with safe operation of a motor vehicle may be present at time of application or renewal for driver's license. An applicant also may not be licensed if he or she has frequent or impairing episodes of hypoglycemia, or if there is evidence of alcohol or drug use sufficient to interfere with his or her diabetes management program.

6. **In KY,what is the state's policy about episodes of altered consciousness or loss of consciousness that may be due to diabetes?**

Any episode of loss of consciousness results in a 90 day suspension. The applicant must remain episode free for 90 days following the last known episode in order to have the license reinstated. A person whose seizure condition is of a nature that the seizure condition would not impair the ability to operate a motor vehicle may present evidence of this fact to the licensing agency, including the person's own attested statement, physician's statement, and medicine dosage details. If the division determines that the person's condition does not impair the ability to operate a motor vehicle, the Division will issue the license

7. **In KY, what is the process for appealing a decision of the state regarding a driver's license?**

The individual has the right to an informal hearing before the Medical Review Board and must request a hearing within 20 days of receiving notice of a decision to suspend or restrict a license. The Board will issue a decision within 10 working days, and the individual may appeal this decision through a formal administrative hearing.

8. **In KY, may an individual whose license is suspended or denied because of diabetes receive a probationary or restricted license?** Yes.

9. **In KY, is an identification card available for non-drivers?**

Yes.

Resources
Driver licensing in Kentucky is administered by the state Division of Driver Licensing.

Save the Date -

October 20, 2005

Paroquet Springs Conference Centre
Shepherdsville, KY

(15 minutes from the Louisville Airport)

For a continuing education offering & celebration . . .

Invited Faculty includes (alphabetically):

- *Carlos Hernandez, MD*
- *Steven B. Leichter, MD, FACE*
- *Condit Steil, PharmD*
- *Frank Vinicor, MD*
- *Nancy Walker, RD, CDE*
- *Joanne Westerfield, RN, CDE*

This event will include celebratory moments of the 25-year Anniversary of Kentucky's Diabetes Prevention and Control Program.

For Information Contact:

Theresa Renn, BSN, RN, CDE
Kentucky Diabetes Prevention & Control Program
Frankfort, KY
Phone: 502-564-7996

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KADE Professional Education Co-Chair
DiabetesCare&Communications
Lexington, KY
Phone: 859-223-4074

Kim Jackson, BSN, RN, CDE
GLADE Professional Education Chair
KDPCP-Louisville Metro Health Department
Louisville, KY
Phone: 502-574-6663

Twynette Davidson
Juvenile Diabetes Research Foundation
Louisville, KY
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Leslie Scott, ARNP, CDE
Kentucky Diabetes Network—Professional Ed Workgroup
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Burlington, KY
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TRADE Professional Education Chair
KDPCP-Green River District Health Department
Owensboro, KY
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Paula H. White, MS, RD, LD
KDPCP-Cumberland Valley Dist. Health Dept
London, KY
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Vasti Broadstone, MD
Kentuckiana Endocrine Club & AACE Ohio Valley Chapter
New Albany, IN
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Dana Graves, MSN, RN, CDE
KADE Professional Education Co-Chair
Saint Joseph Hospital-Diabetes Treatment Center
Lexington, KY
859-313-1282

SABRINA'S HOME VISIT MAKES LIFE BETTER FOR NEEDY DIABETES PATIENT

Ruth Woolum, Hazard Perry County Community Ministries

Sabrina Feltner, Family Health Navigator with Hazard Perry County Community Ministries, Works with Diabetes Patients Regarding Difficult Needs

Recently selected as part of the Southeast Diabetes Collaborative, Hazard Perry County Community Ministries, Inc. utilizes an innovative quality improvement approach to provide a comprehensive program with tremendous potential for improving diabetes treatment and outcomes in some of our most vulnerable Kentucky populations. Staff who work for Hazard Ministries know first-hand the difficulty many patients face in dealing with diabetes and also realize that basic needs have to be met before any progress in diabetes care can occur.

Sabrina Feltner, Family Health Navigator, recently did a home visit with a 61-year-old woman who was participating in Diabetes Disease Management through the Collaborative. As a navigator, Sabrina typically provides patient education, outreach, evaluation of self-management goals, and basic support. On this particular visit, Sabrina asked the patient what she had had to eat over the last day or so. The patient responded:

- Yesterday -- Breakfast – a can of peas and kool-aid
- Yesterday -- Lunch – hamburger buns (after scraping the mold off)
- Yesterday -- Dinner – NOTHING
- Today -- Breakfast – NOTHING

Sabrina assurred the patient that she would immediately check on resources to help her obtain food. Sabrina returned back to the clinic and asked Etta Draughn, her fellow navigator, if she had any idea how to obtain emergency funds for food. Etta reminded Sabrina about the *"Abigail's Cookie Jar"* money that a local donor gives to Community Ministries for food.

Sabrina and Etta used the *"Cookie Jar"* money to purchase groceries for the patient and took them to her home. The patient thanked them and said that she was going to tell her grandson that he could now come visit her as she had food to feed him.

Thus the staff of Hazard Health Ministries strongly believe that merely seeing patients in the Clinic is not enough. They feel the home visits and enabling services are equally important. For it is through these services that the diabetes patients are able to receive the needed support and encouragement in their home, between clinic visits, to maintain their self-management goals and gain better control over their illnesses!

HEALTHY VISION "COMMUNITY AWARDS PROGRAM" OFFERING FUNDING

The National Eye Institute (NEI) is pleased to announce the 2006 Healthy Vision Community Awards Program. This program provides funding for the implementation of health education activities that support the Healthy Vision 2010 objectives and the Healthy People 2010 goals to reduce health disparities and improve quality of life.

The focus of the 2006 awards will be on diabetic retinopathy, glaucoma, occupational eye injury, personal protective eyewear, and vision rehabilitation.

Nonprofit organizations, including but not limited to community-based organizations and groups, minority-based organizations, schools, faith-based organizations, civic and fraternal groups, and State and local health departments and agencies are eligible to apply for an award. Universities and university affiliations, such as medical centers, are precluded from receiving an award directly, but are welcome to submit for an award as collaborators with community-based organizations. Each award is worth up to $10,000 per year. Applications must be postmarked by Wednesday, August 31, 2005.

For more information about the Healthy Vision Community Awards Program, visit www.healthyvision2010.org/news or http://www.healthyvision2010.org/news.

ASIAN AMERICAN AND PACIFIC ISLANDER DIABETES EDUCATION RESOURCE LIST DEVELOPED

The Asian American and Pacific Islander(AAPI) population in the United States is growing rapidly. According to the U.S. Bureau of the Census, from 1990-2000 the Asian population in the U.S. increased by 48%, while the Native Hawaiian and Pacific Islander population increased by 9%. In working with diverse populations such as Asian Americans and Pacific Islanders, it is critical that diabetes educators utilize appropriate tools that are culturally sensitive that encourage positive self-care behaviors.

For diabetes professionals taking care of Asian Americans and Pacific Islanders with diabetes, the Association of Asian Pacific Community Health Organizations (AAPCHO) has developed a diabetes resource sheet which may be obtained from **AAPCHO,** 300 Frank H. Ogawa Plaza, Suite 620 Oakland, CA 94612, Tel: (510) 272-9536 Fax: (510) 272-0817, or www.aapcho.org .
The resource sheet is organized into six categories:
1) Educational Materials; 2) Government; 3) Literature; 4) Nutrition; 5) Providers; 6) Research Centers, Institutions, Professional Associations, Community-Based Organizations.
The resources were compiled using AAPCHO's partner networks and on-line searches.

Please note that extra consideration should be taken when downloading translated AAPI health education materials over the Internet. Due to the intricacies and nuances of many AAPI languages, miscommunication can occur if a material and its contents are printed inaccurately. AAPCHO encourages providers to request hard copies of a specific translated material directly from the developer.

Educational Materials are as follows:

BALANCE Program for Diabetes, Steps to Manage Your Diabetes brochures:

These brochures provide bilingual facts and steps for effective diabetes self-management. BALANCE offers Steps brochures in Chinese, Korean, Samoan, Tagalog, and Vietnamese. Brochures are free to download from the AAPCHO website in PDF form as well as free to order in hard copy form.

Order form: http://www.aapcho.org/download/aapcho.pdf
Chinese
http://www.aapcho.org/download/StMYD-Chinese.pdf
Korean
http://www.aapcho.org/download/StMYD-Korean.pdf
Samoan
http://www.aapcho.org/download/StMYD-Samoan.pdf
Tagalog
http://www.aapcho.org/download/StMYD-Tagalog.pdf
Vietnamese
http://www.aapcho.org/download/StMYD-Vietnamese.pdf

BALANCE Program for Diabetes, Recommended List of Multilingual Diabetes Educational Materials
BALANCE has compiled this recommended list based on evaluations from teams of bilingual reviewers and their recommendations.
http://www.aapcho.org/download/RecList_Topic.doc

EthnoMed: Ethnic Medicine Information from Harborview Medical Center
EthnoMed contains information about cultural beliefs, medical issues, and other related issues pertinent to the health care of recent immigrants and/or refugees primarily in Seattle.
http://ethnomed.org/ethnomed/clin_topics/index.html#diabetes

Multicultural Diabetes Resources
Prepared by the Minnesota Diabetes Program, the site contains links to cultural competency resources.
http://www.health.state.mn.us/diabetes/pdf/multiculturalresources.pdf

New South Wales Multicultural Health Communication Service
Funded by NSW Department of Health, the site provides articles and resources to help health professionals communicate with non-English speaking communities throughout New South Wales.
http://www.health.nsw.gov.au/health-public-affairs/mhcs/publications/Diabetes.html

Selected Patient Information Resources in Asian Languages (SPIRAL)
SPIRAL provides electronic access to health information for consumers and health care providers as well as consumer information in AAPI languages, specifically: Chinese, Cambodian, Vietnamese and Laotian.
http://www.library.tufts.edu/hsl/spiral/

"Advanced Diabetes Management: Teaching Your Patient to Drive the Bus" to be held September 30th

The Tri-State Association of Diabetes Educators (TRADE), an affiliate of the American Association of Diabetes Educators (AADE), and the Kentucky and Indiana Diabetes Prevention & Control Programs, are planning the 22nd Annual TRADE Workshop, ***Advanced Diabetes Management: Teaching Your Patient to Drive the Bus.*** The workshop will be held September 30th at Trover Clinic in Madisonville, KY from 11:30-4:45. For a brochure, contact Deborah Fillman at 270-852-5581 or email deborah.fillman@grdhd.org .

This workshop will feature:

- An opening luncheon with opportunity to network with other diabetes educators.
- Diabetologist, Jane Bridges, MD, sharing her "no nonsense" approach to diabetes education.
- A free copy of Dr. Bridges book, ***Advanced Diabetes Management: Learning to Drive the Bus.***
- Exhibitors offering a variety of product samples, tips, and information to assist diabetes educators in the education of patients.

The 22nd Annual TRADE Workshop is being shortened this year to a half day event as TRADE will also be involved in providing the 25th Anniversary Celebration/ Diabetes Conference of the Kentucky Diabetes Prevention & Control Program (KDPCP) And Partners, ***Diabetes Care and Prevention: the Past, Present, and Future*** on October 20, 2005 in Shepherdsville, KY (15 minutes from the Louisville airport) (see details elsewhere in this newsletter). If you would like more information or a brochure regarding the Diabetes Celebration/Conference, please contact Janice Haile at 270-852-5562 or email janice.haile@grdhd.org .

Both of these seminars will offer continuing education hours for nurses, dietitians, and pharmacists. In addition, both seminars should allow diabetes educators to meet certified diabetes educator requirements for recertification.

Medicare To Offer New Program For Prescription Assistance

Beginning January 1, 2006, new Medicare prescription drug plans will be available to people with Medicare. Insurance companies and other private companies will work with Medicare to offer these drug plans which will offer discounts on drug prices. These plans are different from the Medicare-approved drug discount cards, which will be phased out by May 15, 2006, or when your enrollment in a Medicare prescription drug plan takes effect, if earlier.

Medicare prescription drug plans provide insurance coverage for prescription drugs. Like other insurance, there will be a monthly premium (generally about $37 in 2006) and a shared cost of the prescriptions. Costs will vary depending on the drug plan chosen.

Drug plans may vary in what prescription drugs are covered, how much you have to pay, and which pharmacies can be used. All drug plans will have to provide at least a standard level of coverage, which Medicare will set. However, some plans might offer more coverage and additional drugs for a higher monthly premium.

Some people with an income at or below a set amount and with limited assets (including savings and stocks, but not counting the home) will qualify for extra help. The exact income amounts will be set in 2005. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions.

In the fall of 2005, the "Medicare & You 2006" handbook will list the Medicare prescription drug plans available in specific areas. Personalized information will also be available in the fall at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227).

MARK YOUR CALENDAR FOR

SEPTEMBER 30TH & OCTOBER 20TH

AND MAKE PLANS TO ATTEND BOTH PROGRAMS!!

LIVE - A - BE – TES *MY PERSONAL DIABETES PERSPECTIVE*

By: Kim Loughry as told to Deborah Fillman, KDPCP Regional Coordinator, Green River District Health Dept; KDN member; TRADE member

Kim Loughry, wife of Dewaine and mother of Ian and Josh

My life with diabetes has had its ups and downs. I don't take insulin or diabetes pills. In fact, I don't follow a special meal plan or check my blood sugar. **But you see, diabetes is a significant part in my life, even though I don't have the disease.**

Diabetes became a part of my life when I started dating my husband, Dewaine, back in the 1970's. I knew he had diabetes, (he was diagnosed when he was 14 years old) but I really wasn't aware of the consequences diabetes could have in a person's life. It wasn't until we were married almost a year that I had my first glimpse of what can happen with diabetes. I woke up one morning and found Dewaine sitting on the side of the bed, drenched in sweat. I had no idea what this meant, so I called his mother who told me to get him to the emergency room. I immediately took him to the emergency room and their first question to me was, "What kind of drugs was he on?". That was when I first began my personal journey in "diabetes education" and that was almost 23 years ago.

Since that time, let us say my "education" has been greatly enhanced!! When we married, Dewaine didn't have a meter, or a pump, didn't count carbohydrates and had not had any diabetes education. Unfortunately, we did not have "formal diabetes education" until 1993. And also unfortunately, Dewaine had his first stroke in 1994 at the age of 35. This was our first major diabetes complication. After this, I knew we had to find an endocrinologist to help us deal with this disease.

By 1996, it became apparent that "we" were facing a pancreatic and kidney transplant. Now out of necessity and like a baptism by fire, I would become more educated about insurance processes and advocating for coverage! I wrote letters and dealt with appeals for 10 months to get approval to have the transplants at the University of Kentucky in Lexington, rather than going to another state. After finally getting approval for the transplants, it was another 6-7 months before we received "the call" that a transplant was available. When we received "the call", we had one hour to get to the hospital! Dewaine and I were both at work, but dropped everything and started a journey that would change our lives forever. What do you say to each other during a time like this? I thought we should say something, but Dewaine wouldn't say a word except, "Don't worry".

The transplant surgery (December 1997) lasted about 8 hours and Dewaine was in the hospital only 1 ½ weeks before going home …he was home for Christmas! But, by New Year's Eve, he was back in the hospital -- this time for almost 2 months. He was confused, distracted, could not keep his medications down and lost a lot of weight. He didn't even know who I was. I stayed at the hospital almost the entire 2 months even though we had 2 young children at home. Dewaine finally came home on a feeding tube.

But, Dewaine's health did improve and life was good. We were involved in our children's sporting activities and Dewaine was able to go back to work! The pancreas lasted almost 2 years. So, for those 2 years, we did not have to deal with insulin or blood glucose testing! It was great!

After the first transplanted pancreas stopped working, we considered having another pancreatic transplant. But, this wouldn't happen before our son, Ian, was diagnosed with diabetes in April of 2000. He was 14 …the same age his dad was when he was diagnosed. I remember sitting in the bathroom crying and thinking, what is this child going to endure? But, Ian never had any problems sticking himself for insulin injections or blood sugars. He's an athlete, competing on the state football team for 4 years --- he has played basketball and pole vaulted. Ian never had any real issues with diabetes …except the name of the disease. He has said, "Why would anyone name a disease die - a - be - tes (diabetes)?" "Nobody wants to DIE!" " Why don't they rename it Live - a - be - tes??"

One month after Ian was diagnosed with diabetes, Dewaine had his second pancreatic transplant in May of 2000. This time I didn't have issues with the insurance companies and Dewaine didn't have the medical problems as before. But this time, the pancreas lasted less than a year. Was it worth it? Dewaine definitely says yes, because of all that time "off" from having to take injections or check blood glucose levels. Dewaine has had 3 strokes since his last transplant. However, he has persevered and is doing well today. He's very active in the community and church activities and is especially happy having an insulin pump!

Ian is now a sophomore at Western Kentucky University. He also has an insulin pump and is doing very well in school! His brother, Josh, likes to tease Ian and will often say, "You better do something with him, I think his blood sugar's low"…even though I know it's just brothers trying to get on Mom's nerves!

There's no way I could begin to count the glucose test strips, syringes, doctor's appointments, lancets, or other diabetes supplies we've used in our household! I feel that the one change in diabetes care over the years that has been the best change for us --- is allowing more flexibility in eating and using carbohydrate to insulin ratios.

I can't possibly measure the heartache, pains, joys or successes we've experienced because of diabetes. But I can use my experiences hopefully to share with others these two thoughts:

"*Search until you find the people who are sensitive to what you are saying…whether it's your pharmacist, diabetes educator, doctor, or other healthcare provider helping with your diabetes needs"*

And, " Everyone with diabetes needs to see a diabetes educator!"

KENTUCKY PHARMACY PROGRAM RECEIVES NATIONAL HONORS

Members of the American Pharmacists Association Foundation and Wyeth, sponsor of the Pinnacle Awards, Congratulate UK Pharmacists Holly Divine (front row left) & Amy Nicholas (front row right) for winning the National Pinnacle Award in the Group Practice/Health System/Corporation Category

The American Pharmacists Association (APhA) Foundation honored the University of Kentucky (UK) College of Pharmacy's PharmacistCare Medication Therapy Management Services as one of three national winners during the eighth annual Pinnacle Awards June 14 at The John F. Kennedy Center for the Performing Arts in Washington, D.C. Holly Divine, Pharm.D., and Amy Nicholas, Pharm.D., both clinical pharmacists and assistant professors of pharmacy, developed the program and received the award on behalf of the College and the University for the Group Practice/Health System/ Corporation category. Clinical pharmacists Carrie Johnson, Pharm.D., and Mikael Jones, Pharm.D., also have recently been added as members of the medication therapy management services team.

The Pinnacle Award recipients are recognized for pioneering innovative ways to improve the medication use process that increase medication adherence, reduce drug misadventures, improve patient outcomes, and increase communication between all members of the health care team.

UK offers the free program for adult UK health plan members who have been diagnosed with diabetes. Group educational classes, individual follow-up sessions, a quarterly "Living Healthier with Diabetes" newsletter, and continually updated educational materials are geared toward helping individuals gain the best diabetes control. The Kentucky Diabetes Prevention and Control Program's (KDPCP) educational curriculum was used to begin the group classes.

The program has been in place for over 2 full years and currently serves over 100 patients. The group education program is followed by individualized 1 – 3 month follow-up visits with a pharmacist who has expertise in diabetes care. Artemetrx, is a web-based data management tool which is being used by UK to monitor outcomes and document clinical activities. UK is in the process of analyzing the year 2 data and plans to publish the diabetes outcome results.

The award winning program stemmed from UK President Lee Todd's health literacy project implemented to assist with the University's growing health care crisis. Initially part of the REACH (Raising Energy, Awareness and Campus Health) program, the pharmacist-administered diabetes management service has helped employees, retirees and their families improve their health and reduce current and future health care costs for the members and the health care plans administered by the University.

Alan T. Male, Ph.D., a professor of mechanical engineering at the UK College of Engineering, is a diabetic and a strong supporter of the program. "Through this program and its educational classes, I have gained considerable understanding of diabetes and all of its potential long term health implications," Male said. "I am convinced that this program has played a critical part of the health improvement that I have noted over the last couple of years."

Clyde Snapp, a grounds worker in UK's physical plant department, is also a patient and advocate of the program. "I still have a ways to go in reaching my goals, but they are helping me learn what I have to do to feel better and take less medicine," Snapp said.

It has been a tremendous achievement for the UK College of Pharmacy to plan, implement and administer this unique patient care program for University employees and their dependents, said UK College of Pharmacy Dean Kenneth B. Roberts, Ph.D. "This partnership between the College and the UK health plan has resulted in substantial improvements in patient care and quality care to UK and its beneficiaries.

THE MAN WITH DIABETES

There once was a man in his fifties…
Who had had diabetes since his forties.
He saw his doctor on a regular basis…
Yet he had not a clue …
As to his OWN diabetes cases!

Now this Man with Diabetes had a daughter...
Who lived in the same town as her father.
She would ask "her Daddy" about his sugar and fat…
Yet his response always was …
" I don't know "nothin" about that!"

Now, this daughter was a CDE…
And she would beg her father to ask about his A1C.
"Your blood pressure, cholesterol, and lipids too"…
She said…
"Are JUST as important to you"!

But the daughter's voice he never heeded…
He never once asked about what he needed.
Then one snowy January night…
This … Man … with … Diabetes…
Almost … lost his life!

Feeling "not quite right" was what he said …
So an ambulance was summoned to his bed.
He was carried to the emergency room and admitted…
They thought it was his stomach …
"He's at low risk for heart" --- they kidded.

"He has not had chest pain," they said…
"And his EKG was perfectly read."
"So we'll do some tests, come Monday."
"For now … just rest"
"You'll be fine and dandy."

It didn't take long before…
That funny feeling was back … and more.
The nurse gave nitroglycerin (pills) all night long.
But by 6 am, he called his daughter to say…
HE … would soon be gone.

Chest pain negative, color ashen and white…
This Man with Diabetes looked a fright.
A silent MI is what they called it.
He had a heart attack…
It was NOT his stomach!

While still in the hospital, he became galled…
Upon hearing lipid results, after his doctor called.
Elevated -- they told him -- it had been for a while…
Why didn't I know, he said …
So I could have avoided … this bitter bile.

But all was not lost, you see…
As this Man with Diabetes learned his A1C.
He now gets his dilated eye exams…
And … walks daily to improve…
HIS diabetes game plan!

A great lesson was learned by all…
To educate patients about when to call.
Inform about test results…
And what should be done…
To prevent or delay devastating outcomes.

This is not a joke, as the story is true…
And as you know, it could happen to YOU!
That is why I wrote this, you see…
Because, that diabetes educator…
Was me!!

Note: *"The Man With Diabetes"* was a poem written by Janice Haile, RN, CDE which was used as an introduction to a quality care presentation given at a Health Care Excel Seminar in March of 2005.

LILLY TO DISCONTINUE FOUR INSULIN PRODUCTS

On July 6, 2005, Eli Lilly and Company announced that it is discontinuing production of Iletin® II Pork Insulin (Regular and NPH® formulations), and Humulin® U Ultralente® and Humulin® L Lente®(Humulin U and Humulin L) insulin products.

Over the past few decades, newer insulins, such as rapid-acting analogs, analog mixtures, basal analogs and other human insulin products have been developed. As a result, Lilly has noted a significant and steady decline in the usage of the insulin products that will be discontinued.
Given current inventories and patient demand, the products that will be discontinued should still be available in pharmacies through the end of 2005.

For more information, contact
1-800-LillyRx (1-800-545-5979)
Monday through Friday from
8:00 am to 7:00 pm (EST).
or visit, http://www.lillydiabetes.com/

TRADE Diabetes Educator Meetings Scheduled

The Tri-State Association of Diabetes Educators (TRADE), which covers Western KY/Southern IN, meets quarterly from 11 – 2 pm CST with complimentary lunch and continuing education units. To register, call (270) 686-7747 ext. 5581.

The planned meetings include:

September 30, 2005 – Annual workshop (see details elsewhere in this newsletter)
November 2005 meeting to be rescheduled for July 2006

January 19, 2006, Diabetes and Antipsycotic Drugs
Speaker T. Liffich, MD
Location: Deaconess Hospital – Johnson Hall
600 Mary Street, Evansville, IN
Time: 11:00 am-2:00 pm
Sponsor: Sanofi Aventis

GLADE Diabetes Educator Meetings Scheduled

The Greater Louisville Association of Diabetes Educators (GLADE), which covers Louisville and the surrounding area, meets the 2nd Tuesday every other month *(no meeting in August).* Registration required. Please register and direct questions to Dawn Fraze RN, BSN, CDE at 270-769-1601 ext. 129 or dawns.fraze@ky.gov .

Date:	**Tuesday, September 13th 5:30-7:30 pm**
Location:	Napa River Grill on Dutchmans, Louisville
Speaker:	**Dr. George Aronoff, Nephrologist**
Title:	**Diabetes and Kidney Disease**
	AADE Sharing & Chapter Planning

Times and Locations to be announced

Date:	**Tuesday, November 8th**
Date:	**Tuesday, January 10th**
Date:	**Tuesday, March 14th**
Date:	**Tuesday, May 9th**
Date:	**Tuesday, July 11th**

Endocrinologists Meetings Scheduled

The Ohio Valley Chapter of the American Association of Clinical Endocrinologists (AACE) and the Kentuckiana Endocrine Club meet on a regular basis. For a schedule of meetings, contact:
Dr. Vasti Broadstone, Phone: 812-949-5700
E-mail: joslin@FMHHS.com

Kentucky Diabetes Network (KDN) Meetings Scheduled

The Kentucky Diabetes Network (KDN) is a network of public and private providers striving to improve the treatment and outcomes for Kentuckians with diabetes, to promote early diagnosis, and ultimately to prevent the onset of diabetes.

Quarterly general meetings are held from 10-3 pm EST. Anyone interested in improving diabetes outcomes in KY may join. A membership form may be obtained at www.kentuckydiabetes.net or by calling 502-564-7996 (ask for diabetes program).

Friday September 16. 2005 KY History Center (Frankfort)
Friday November 4, 2005 Baptist East Hospital (Louisville)

2006 meeting dates -- Locations to be announced

Friday March 10
Friday June 9
Friday September 15
Friday November 3

KADE Diabetes Educator Meetings Scheduled

The Kentucky Association of Diabetes Educators (KADE), which covers Lexington and Central Kentucky, meets the 3rd Tuesday of every month except summer (time & location vary). For a schedule or more information, contact:
Dana Graves
Phone: 859- 313-1282
E-mail: gravesdb@sjhlex.org
or
Laura Hieronymus
Phone: 859-223-4074
laurahieronymus@cs.com

Meeting Time, Location and Topic to be Announced

August – No Meeting
September 20, 2005
October 18, 2005
November 15, 2005

DECA Diabetes Educator Meetings Scheduled

Diabetes Educators of the Cincinnati Area (DECA), which covers Northern KY, meet the third Monday of each month from 5:30 – 7:30 pm. Anyone interested in diabetes is invited. Please register with Mary Ann Benzing 513-248-9992.

September 19 2005	Location: To Be Announced
October 17, 2005	Location:Bethesda North Hospital
November 21, 2005	Location: Good Samaritan Hospital

Kentucky Diabetes Connection

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The Kentucky Diabetes Prevention and Control Program Paid Printing and Mailing Costs for this Newsletter

Contact Information

American Diabetes Association.
Cure • Care • Commitment
www.diabetes.org
1-888-DIABETES

TRADE
Tri-State Association of Diabetes Educators
www.aadenet.org/AboutAADE/Chapters.html

KDN
KENTUCKY DIABETES NETWORK, INC.
www.kentuckydiabetes.net

KENTUCKY ASSOCIATION of DIABETES EDUCATORS
KADE
Bluegrass/Eastern Chapter
www.kadenet.org

GLADE Greater Louisville Association of Diabetes Educators 1984
www.louisvillediabetes.org

KENTUCKY DIABETES PREVENTION AND CONTROL PROGRAM KDPCP
[redacted] *

JDRF Juvenile Diabetes Research Foundation International
dedicated to finding a cure
www.jdrf.org/chapters/KY/Kentuckiana
1-866-485-9397

DE CINCINNATI A
Diabetes Educators Cincinnati Area
www.aadenet.org/AboutAADE/Chapters.html

ACE American Association of Clinical Endocrinologists
Ohio Valley Chapter
www.aace.com

Kentuckiana Endocrine Club
[redacted] **

* The Kentucky Diabetes Prevention and Control Program has a new updated website. Please visit KDPCP at www.chfs.ky.gov/dph/ach/diabetes.
** Kentuckiana Endocrine Club email address is joslin@fmhhs.com